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An Evaluation of Direct Services of Delaunay Institute for Mental Health

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AN EVALUATION OF DIRECT SERVICES OF DELAUNAY INSTITUTE FOR MENTAL HEALTH

by

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I. INTRODUCTION

We live in an age of "accountability." To a social agency this means being responsible for learning what impact treatment has upon the clients involved and the community in which they live. The following statement reveals pertinent issues and reasons for studying treatment results.

> Any social agency supported by taxpayers' money or voluntary funds, has a duty to study and evaluate its effectiveness and to seek continuously to improve the methods it employs to achieve its objectives. It is not enough to believe, however sincerely, that we are doing good. It is not enough to invoke experience, or to collect meaningless and misleading information. It is not completely honest to spend money on giving attention to people who do not need such attention, or to those who might be better integrated with society if they were not disturbed by unsought ministrations of well-meaning people. It is not enough to rely upon the support of colleagues and those in the same professional group and to accept their endorsement of our work as proof of its effectiveness. Professional in-group support does not measure effectiveness and does not absolve us from accountability for our decisions. The effectiveness of social agencies, it is claimed, is a question to be determined empirically by methods which can be repeated and verified by others.[1]

Today taxpayers (those who pay for services) and clients (those who receive services) wish the best use for the money that they invest. The public is not as accepting of generalities, observations or intuitive success measures of social agencies' performance. Emotional problems are costly. Often they can lead to loss of employment, inefficiency, break-up of marriages, retarding the emotional development of children and use of monies invested by other agencies, i.e., welfare, juvenile courts, etc. Social agencies, in response to the general

public, are raising issues around what are appropriate measures for evaluating treatment outcome. The instant study is one such response on the part of Delaunay Institute for Mental Health. The study attempts to ascertain treatment outcome in the Delaunay program and at the same time test out the PARS (Personal Adjustment and Role Skill) as an evaluative instrument in making treatment assessment.

The task of developing a research design is often difficult because we are attempting and often required to find a systematic approach to study people, each of whom has unique characteristics according to his or her own psychological, physiological and cultural influences. Issues arise regarding who should evaluate treatment results, the client or the therapist? Also what considerations are given to such variables as modes of treatment, therapists' personality and differences in the emotional problems need to be considered.

The PARS, as an evaluative instrument, was developed by Dr. Robert Ellsworth[2,3,4] who was the director of a four year project at the Veterans Administration Hospital in Roseburg, Oregon. The project involved developing an effective and less complex means to evaluate program effectiveness. The PARS was designed to measure the behavioral adjustment of the client in his natural surroundings--the community in which he lives. Dr. Ellsworth used a "significant other person" (preferably a relative in the same household) in the client's life as a rater. He found, contrary to the assumption that relatives are biased, their ratings were as valid as the hospital staff ratings of the patient. Ellsworth concluded that clients behave differently apart from the treatment setting and that if a client relates well to the therapist it does not have significance unless behavioral changes also

occur in the community. The use of the PARS Scale was chosen significantly by Delaunay Institute for Mental Health to measure the effectiveness that their treatment program had upon their clients and the community.

II. SETTING

Delaunay Institute for Mental Health is a community mental health center located at 6419 N. Portsmouth Avenue, Portland, Oregon. The Institute was founded in 1946. Although the clients are primarily from the North Portland area, services are available to the entire Portland metropolitan community.

The Center offers clinical services including outpatient treatment, psychological and psychiatric evaluations and consultation to other community agencies. In addition to clinic services it is involved in training of mental health professionals and research activities.

The staff consists of a psychiatrist-director, a social worker administrator, two psychologists, an ACSW social worker, psychiatric nurse and three clerical workers. Each staff member (with the exception of the clerical workers) is qualified to perform all clinic functions--diagnosis and treatment.

Modes of treatment are based on the client's needs and the therapist's speciality. Currently treatment offered varies from insight, Gestalt, behavioral reality, crisis intervention, to play therapy for children. Individual, marital, family, and group therapy is offered depending on the client's needs.

Trainees currently on staff are two psychology interns from Washington State University at Pullman, Washington, and University of Portland, Portland, Oregon. There are four second year graduate students from Portland State University School of Social Work, Portland,

Oregon.

The research component is the active involvement in evaluating clinical services as to its effect on the individual and the community. The Clinic is part of the Oregon Research Institute that assists in developing measures to assess clinic effectiveness. Research is regarded as an integral activity of the agency and is encouraged and pursued in numerous other areas.

III. NATURE OF THE PROBLEM

Delaunay Institute is a private mental health service that is contracted by the State of Oregon through the State Division of Mental Health to provide mental health care for the North Portland catchment area. As part of the increased pressures upon agencies for accountability, the state requires funded agencies to be part of the MBO (Management by Objective) process. This process is a systematic approach in assessing effectiveness and output rather than a "generalized" evaluation that was deemed sufficient in the past. Additionally the staff at Delaunay Institute feels a responsibility to their clients and themselves in evaluating the impact of treatment on clients and thus a potential for continuing treatment innovation relevant to the needs of the community.

Staff at Delaunay Institute, after assessing various research designs, had chosen the PARS (Personal Adjustment and Role Skill) Scale for program evaluation. The PARS Scales focus on the client and the "significant other" person in that client's life, both of which rate the client's adjustment and are therefore potential measures of treatment effectiveness.

Delaunay Institute began administering the pre-PARS questionnaire to each new client or pair of clients (in the case of people who came in for marital therapy) in November of 1972. The PARS questionnaire was given before the first interview. The Minnesota Multiphastic Personality Inventory was also administered at this time.

After the first interview, a form giving permission for the release of information was signed by each client. In addition, each client was asked to name a "significant other" in his life to which the pre-PARS questionnaire was mailed. After completion, the questionnaire was then returned to Delaunay for scoring.

Delaunay's original research design called for the clients undergoing therapy and the significant others to retake the PARS questionnaire (post-PARS) after three months of therapy. The plan was to mail the post-PARS questionnaire to the clients and significant others and have them returned by mail after completion for scoring and analysis.

At this point two major difficulties in the original design became apparent. Contrary to expectations, it was discovered that the majority of the client population that Delaunay had tested since November of 1972 did not remain in therapy for three months. (See Table VIII, Appendix C, page 35.) Second, it was found that several of the pre-PARS questionnaires for both the self and other had not been completed and returned. For the purposes of this study incomplete questionnaires were then eliminated from further analysis.

At this point we found that the original research design was unworkable and that we would need to develop a new one. We felt it was important to continue to use the PARS questionnaire as efforts had gone into gathering the data. Therefore, we chose to use the PARS in a termination study because we would have some control in establishing the criteria for the selection of our research population.

IV. DESIGN

As was discussed in the previous section, we were forced to change the focus of our study. Our study would involve an attempt to assess treatment outcome for clients who have terminated treatment from Delaunay Institute. "Terminated" clients refer to those who are not scheduled for future appointments either by mutual agreement between the client and therapist or those clients who have not been seen at Delaunay for the past six weeks.

The Test Instrument

The instrument used for assessing treatment income is the PARS Scale (refer to previous references 2, 3, and 4). The PARS Scale is a 57-item questionnaire measuring seven factor areas, which differ slightly between male and female. It is administered to the client and a "significant other" person (preferably a relative in the same household) at the beginning of treatment and at termination of treatment.

The seven factors attempt to translate abstract concepts of psychopathology into concrete behaviors that are observable to the raters. The factors for males and examples of concrete behaviors are (1) interpersonal involvement--shows consideration for and interest in the significant other; (2) confusion--loses track of time; (3) anxiety--difficulty sleeping and eating, feels nervous; (4) agitation-depression--feels upset or feels others don't care; (5) alcohol-drug abuse--drinks to excess or becomes high; (6) employment--is employed or looking for

employment; and (7) outside social--attends activities outside the home. For the female client anxiety is dropped and household management is added--shops, prepares dinner, etc. Employment becomes an optional factor and parenthood skills for both male and female are optional depending on whether there are children in the household.

Selection of Population and Test Administration

The criteria developed for inclusion in the research population are: (1) the client must have undergone at least three therapy sessions; (2) the client must have terminated from treatment; and (3) the client must have terminated between June 1 and September 15, 1973. The last criterion was added because we wanted to measure treatment effects as close to the end of therapy as possible. By implementing these new criteria we obtained a population of 48 patients. Of these, 16 of the pre-PARS had either the self or significant other questionnaire missing. Therefore we did not gather post-PARS data on the 16 patients with incomplete pre-PARS data.

Next we mailed a letter (see Appendix A, page 29) to the remaining clients and their informants along with a copy of the post-PARS questionnaire, explaining that we would call on them soon to arrange for return of the questionnaire. We phoned the remaining 32 clients in two to three weeks and made arrangements to pick up the completed PARS questionnaires. In this way we hoped to get a better response than if we relied on mailed returns.

We encountered numerous problems in obtaining the post-PARS data. Many clients had either lost the questionnaire or had failed to complete it. Thirteen of the clients were either uncooperative (in spite of the

fact that they had signed an agreement stating that they would participate in evaluation at a later date) or we were unable to locate them. We made two to three phone calls to each client and were greeted with mixed sentiments. Some clients were open and cooperative; others were evasive. We made home visits to most of the clients and their informants, and a few individuals preferred to mail their responses to Delaunay.

This left a total sample of 19 complete sets of pre and post data. Table I shows the demographic traits of the 19 patients.

TABLE I

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

n = 19

Treatment Category	n
Adult Psychiatric	15
Hospital Follow-up	1
Drug Problem	1
Marital Counseling	1
Adolescent	1

Income	n
Under $3,000	9
$5,000 - 5,999	2
$6,000 - 6,999	1
$8,000 - 8,999	1
$9,000 - 9,999	3
$10,000 - 14,999	1
$15,000 - 19,999	1
Over $20,000	1

TABLE I, Continued

Marital Status

	n
Married Once	9
Remarried	1
Married but Separated	2
Divorced	4
Never Married	3

Education

	n
High School or Less	16
Some College or Degree	3

Sex

	n
Female	11
Male	8

Age

$\bar{x}$ = 32 Range 16 - 46

V. ANALYSIS

Since our final number of completed sets of PARS data was small (19) we decided to run three tests to learn if our population of 19 was representative of the original population of 48. We tested on factors of age, sex, and self administered pre-PARS Factor "A" (Interpersonal Involvement) scores. We ran F tests on Age and Factor "A" scores and a test for the standard error of the difference between two proportions on sex. We chose to look at these three areas because we felt that demographic factors such as age and sex are good basic indices of "alikeness" and that Factor "A" seemed to us to be an overall measure of social behavioral functioning.

TABLE II

SIGNIFICANCE TESTS BETWEEN STUDY SAMPLE AND INCOMPLETE SAMPLE ON SELECTED VARIABLES

Age

Complete		Incomplete
$n = 19$		$n = 27$
$\bar{x} = 32.37$		$\bar{x} = 31.44$
$\sigma = 8.53$		$\sigma = 9.57$
	$F = 1.57$	

Pre-PARS Self Administered Factor "A" Score

Complete		Incomplete
$n = 17$		$n = 29$
$\bar{x} = 34.06$		$\bar{x} = 35.79$
$\sigma = 5.62$		$\sigma = 4.84$
	$F = 1.35$	

TABLE II, Continued

Sex

(p_1 = proportion of males; q_1 = proportion of females)

Complete		Incomplete
n = 19		n = 29
p_1 = .421		p_2 = .379
q_1 = .579		q_2 = .621
	z = .289	

On the basis of these three tests, we accepted the null hypothesis in each of them. We concluded that any differences between the 19 complete sets of PARS data and the remainder of our population on these three traits at least were due to chance.

From this point on we confined ourselves to an analysis of the 19 completed pairs of pre- and post-PARS data.

We did an analysis of variance on net change scores for the first three PARS factors. The four groups we analyzed on these factors were the male self and his informant, and the female self and her informant. We found that the variance between these groups was not statistically significant at the .05 level on any of these factors. We therefore concluded that we could not say that there was more variation between groups than within groups. In fact, there was considerable variation in individual change scores within groups. In most instances the majority (50% or more) of the individual self or informant raters saw change in a positive direction.

More of the self raters saw positive change than did the informant raters, and in a majority of the cases, female self and informant raters saw more positive change than the males.

Further evidence of this can be seen in Table III (see Appendix B, page 30). Here we computed the proportions of male and female, self and informant raters who saw change in a positive direction on all of the PARS factors. Again, we found that when self and informants were combined, regardless of sex, a majority of the raters saw improvement. However, we also found that when we separated self and informant ratings more of the self raters saw improvement than did the informants regardless of sex. And, as before, when sex was taken into account more female self raters saw improvement than male self raters. This did not hold true for the informants.

A series of t tests were calculated to determine the statistical significance of our various change scores. As shown in Table IV (see Appendix B, page 31), the direction of change is generally toward improvement across all the PARS factors, but few of these figures reach statistical significance. This table quantifies the net direction of change as seen by male and female, self and informant raters. Statistically significant change was found for males in the Outside Social factor and for females in the Confusion factor. The direction of change in both instances was toward improvement.

Tables V and VI (see Appendix B, pages 32 and 33 respectively) are t tests for the significance of the difference between the mean pre- and post-PARS scores for male and female self and informant raters. Unlike Table IV, these tables are not illustrative of the direction of change. They instead illustrate the differences between mean pre and post scores. Again, the majority of these figures do not reach statistical significance, so we cannot conclude that the majority of the pre-post means are significantly different at the .05 level,

regardless of whether or not the change was in the positive or the negative direction.

Statistically significant differences for men were found for both self and informant raters in the Anxiety factor and for self raters only in the Confusion factor. For females, the self-rated differences between mean scores for Agitation-Depression, Confusion, and Employment were significant. These were all changes in the positive direction. There were no statistically significant figures for female informants.

Table VII (see Appendix B, page 34) summarizes the correlation (r) of the agreement between self and informant raters on the pre-PARS and the post-PARS questionnaire. As can be seen, 10 of the 16 correlation coefficients were higher for the post-PARS than for the pre-PARS. The "average agreement" as measured by a mean of correlations over all factors was higher for males at termination than when treatment began, but it was lower for females. Thus, although there was higher agreement on most of the factors at termination, there was much lower agreement on a few of the other factors, particularly for female raters. On the factor with n of 2, the standard error of the correlation was .14.

VI. REVIEW OF LITERATURE

Because we encountered so many problems in this study and because we wanted to compare our findings to those that had been obtained in previous studies, we did a short review of the literature.

In his article, "The Outcome Problem in Psychotherapy,"[5] David H. Malan, D.M., attempts to summarize aspects of the history of psychotherapy research, with special reference to dynamic psychotherapy, during the past twenty years. We chose to examine this piece of literature because it is one of the most up-to-date and comprehensive articles dealing with psychotherapy research. According to Dr. Malan, a thorough look at the literature reveals that evidence for the effectiveness of psychotherapy is stronger than supposed. However, one difficulty has been integrating research findings with clinical practice.

Dr. Malan claims that psychotherapy research in the early 1950's came up with little in the way of concrete results. Research since then has been much more productive. Nevertheless, until quite recently, research on psychoanalysis[6] has been sparse and inconclusive.

Trends in Psychotherapy Research, 1952-1971

The first comprehensive study of the crucial outcome problem was done by Eysenck in 1952.[7] His study seemed to show that about two-thirds of neurotic patients improved no matter how they were treated or even if they were not treated at all. Naturally, this finding resulted in much criticism, but only recently did this take the form of criticism

based on scientific re-analysis of Eysenck's original data.

In 1956, Desmond Cartwright wrote a little-noticed article refuting a study done by Barron and Leary which had obtained results similar to Eysenck's.[8] Cartwright showed that although the average improvement of both treated and non-treated individuals was the same, the variation in improvement between the groups was greater for the treated group. This would imply that therapy was causing some individuals to improve greatly while others deteriorated significantly.

While Cartwright's work attracted little attention, five other events related to psychotherapy research were occurring. The first was the Psychotherapy Research Project of the Menninger Foundation[9] dealing with psychoanalysis and psychoanalytically based psychotherapy. A second was the continued research in client-centered therapy which had been started by Carl Rogers. A third was the series of studies on dynamic psychotherapy at the Phipps Clinic under Jerome Frank. A fourth was the progress of behavior therapy and the fifth was a series of three conferences on Research in Psychotherapy in Washington, D.C. (1958); Chapel Hill, North Carolina (1961); and Chicago (1966).

Conferences on Research in Psychotherapy

An examination of the papers presented at the first conference shows that they were more concerned with the process of psychotherapy research than the outcome. However, the second conference contained four papers dealing with the correlation between outcome and patient and therapist variables. In the third conference, the trend once again moved away from the outcome problem, dealing instead with behavior therapy and LSD. During this time Strupp complained that research had

little effect on the practice of psychotherapy. Also during this time, researchers in behavior therapy were able to make advances in quantifying the success of this form of therapy.

Client-centered researchers also studied therapist variables and found that with schizophrenic patients, therapists favoring "responsible self-determination" rather than "obedience and conformity" were more effective. However, with adult neurotic patients, the results were just the opposite.[10]

Rogers, Truax, and later Bergin[11] studied the "deterioration effect" that had been present in earlier studies that had shown little positive improvement after psychotherapy. It was shown that some therapists made patients significantly better, and some significantly worse. Therefore, in line with Cartwright's 1956 paper, it became apparent that psychotherapy was actually effective in many instances, despite the fact that it was strikingly ineffective or even harmful in others. Truax and Carkhuff[12] were able to identify therapist variables that led to patient improvement. These were nonpossessive warmth, genuineness, and empathy. Absence of these factors led to deterioration.

Bergin's 1966 paper "Some Implications of Psychotherapy Research for Therapeutic Practice"[13] was an important contribution to research in the field. He concluded that most forms of therapy made patients both worse and better. This accounts for the lack of average improvement found so often in studies comparing treated patients and controls. He also found that untreated patients' symptoms improved after time. Another conclusion was that the only interview-oriented therapy that consistently yielded positive results was the client-centered approach. Further he found that therapist characteristics such as warmth, empathy,

adequate adjustment, and experience correlated positively with patient improvement. Bergin concluded that some patients are not helped by interview-oriented psychotherapy and some types of symptoms are helped by behavior therapy. However, this all may be said of untreated patients.

Strupp and Bergin's 1969 paper "Some Empirical and Conceptual Bases for Coordinated Research in Psychotherapy"[14] considered the climate and possibilities for large scale collaborative research. They concluded that although practitioners had taken little heed of research findings in the past, there was an atmosphere conducive to large scale investigation of psychotherapy outcome. They reported the trends as being "a strong reaction against individual one-to-one psychotherapy," the relegation of intrapsychic changes "to the background in favor of behavioral changes," and "an increasing disaffection from psychoanalysis."

In "The Handbook of Psychotherapy and Behavior Change,"[15] Bergin re-examined Eysenck's figures as well as surveying the literature. He concluded that (1) "spontaneous" improvement rates were much lower than Eysenck had claimed, actually around 30%; (2) two major problems in psychotherapy research are (a) what is the quantitative difference between improved and slightly improved and (b) whether or not early drop-outs should be included as therapy failures. However, according to Malan, it seems that Bergin's figures on spontaneous remission rates are no more reliable than Eysenck's. Malan advocates properly controlled studies.

Meltzoff and Kornreich evaluated 101 research studies in 1970 and found that the majority of these studies supported rejection of the null

hypothesis, and that in general, the better the quality of the research, the more positive the results obtained.[16] According to Malan, if we accept marginal evidence as Eysenck did, we can no longer say that on the average there is no difference between treated patients and controls. If, however, we require Meltzoff's 101 studies to have a six month follow-up and that treated subjects be both patients (as opposed to volunteers) and adult and non-psychotic, the list is reduced to four. There were no studies out of the 101 that dealt with adult psychoneurotic outpatients.[17]

Ending his review of the literature, Malan stated that: (1) "the evidence for the effectiveness of psychotherapy is now relatively strong"; (2) dynamic psychotherapy is effective in psychosomatic conditions; but (3) the evidence for the success of dynamic psychotherapy in treating neuroses and character disorder "is weak in the extreme."[18]

One theme running through all this since the 1950's has been the disillusionment with psychotherapy research in general. Even such eminent people in the field as Carl Rogers, Matarrazzo, Truax, and Strupp and Bergin have expressed such feelings. Bergin stated that positive results could be found if adequate means could be developed.

In contrast to this somewhat pessimistic outlook, the Menninger Foundation's Psychotherapy Project[19] was published in which adequate and fair outcome criteria were established (The Health-Sickness Rating Scale). The importance of the transference relationship was reemphasized as was the judgement of the experienced clinician and, in contrast to Strupp and Bergin's pessimism about the lack of effect of research on practice, the findings of the Menninger study were put to use in the Menninger Clinic. Malan also found that his research

findings at the Tavistock Clinic were put into practice there.

Conclusion

Strupp and Bergin many times have spoken of the lack of impact of research on clinical practice. Much of this, says Malan, is due to a single factor, the "failure to design outcome criteria that do justice to the complexity of the human personality."[20] Once this is achieved, as it was in the Menninger and Tavistock studies, direct clinical applications immediately follow. Meaningful outcome criteria and meaningful variables, which presently have to be based on clinical judgement, are necessary in Malan's opinion. But he also points out that we must be candid in identifying not only which therapies work with which type of patient, but also which therapies do not work with particular types of patients. We must not be overly depressed by negative findings, but rather proceed to look for meaningful outcome criteria and ways of applying research to practice. Finally the question Malan asks is "where are the researchers to come from?"

VII. CONCLUSIONS AND RECOMMENDATIONS

From our analysis we found that most clients changed in a positive direction, but not significantly. Therefore, statistically, more of the self raters tended to see themselves as improved than the informants did; more self and informant raters tended to agree on the post-PARS than on the pre-PARS.

Regarding the research design, we found that the plan to administer the post-PARS after three months of therapy was unrealistic in view of the pattern of client termination (see Table VIII--Appendix C, page 35). Also, more data was lost than was anticipated and mailed responses are not dependable. Ellsworth cited this as one of the major technical problems when using an informant away from the treatment setting.[21] We feel it would be valuable if some alternate method could be used in gathering the data.

Another significant aspect of our research (and one that could well account for the lack of significant change scores) is the fact that there were no adequate controls for: (1) client variables (such as presenting problem and demographic factors) and (2) therapist variables (including treatment modality and individual therapist personality factors). From the literature, we can see the importance of having adequate controls on these factors, and the effect that lumping the data together has on the mean for net change. Further, the wide variation in change scores that we found within groups in our analysis of variance could be a reflection of what was strongly emphasized in the

literature: some clients get significantly better and some significantly worse in therapy depending on who is doing the therapy and what kind of therapeutic modality is employed. We feel that this is an important issue, and one area with which our research project did not deal.

In this study we set out to answer three questions: what effect does treatment at the Delaunay Institute for Mental Health have on its clients, is the PARS questionnaire a viable research tool for Delaunay use, and should it be retained? Unfortunately, we cannot give a decisive answer to the first of these questions. Due to methodological difficulties, we were forced to base our study on a relatively small group of data. We did find an encouraging trend toward positive change, but the figures were not significant. We predict, however, that if more adequate controls on variables were used in the future, more significant results would be obtained along the lines of those found in the literature. Some clients would improve more than others; some would get worse; and some types of therapy would be more effective than others with certain clients.

In light of this, we recommend the continuation of research efforts using the PARS questionnaire but with greater emphasis on controlling client and therapist variables. This is imperative. We would also advocate periodic sampling and testing of clients with follow-up studies, rather than testing every new client.

Further, we see a glaring need for more complete and accurate collection of data by Delaunay.

We would hope the Delaunay (ideally with the active involvement of therapists) would some day attempt to develop a more concise rating

scale to measure treatment effectiveness which might obtain satisfactory results and be less complicated to administer and score than the PARS. In such a rating scale, perhaps more reliance could be placed on therapist ratings of client improvement if these could be put into quantifiable terms. We feel that if the agency were supportive of critical self examination, perhaps this would inspire individual therapists to take it upon themselves to do more research on their own treatment methods and their effectiveness. Therapists could then determine where they succeed and where they fail (whom they are helping and whom they are not) without necessarily needing to worry about how they measure up against other therapists within the clinic who may or may not have different philosophical and practical treatment approaches than they.

Lastly, we urge that findings from research be used by therapists in their practice, both for their own professional betterment and for the welfare of the clients. Otherwise, the ethics of data collection and research without corresponding application to practice are questionable.

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[17]Malan, p. 724.

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APPENDIX

6419 N. PORTSMOUTH AVENUE, PORTLAND, OREGON 97203 · 285-9871

DELAUNAY INSTITUTE
For Mental Health
TREATMENT TRAINING CONSULTATION RESEARCH
19 46

APPENDIX A

Mr. John Jones
Address
Portland, Oregon

Dear Mr. Jones:

Delaunay Institute is conducting research to determine the effect of its treatment methods. As a former client we are interested in how your experience with this agency affected you. As you recall, you filled out a brief questionnaire when you first came to Delaunay Institute. At that time you indicated your willingness to complete another at a later date. Now we would appreciate it if you would take a few minutes to complete the enclosed questionnaire. We will be using your responses as data to determine what impact we have on our clients and also whether this method is effective in measuring treatment results. Your response will be completely confidential and will be used only for the stated purpose. Client names will not be used after this contact. Your cooperation is essential in order that we may evaluate our program.

Please complete the questionnaire as soon as possible. We will be contacting you early in December to make arrangements to pick up the completed questionnaire. Please feel free to contact Delaunay Institute if you have any questions regarding this matter.

Again your cooperation will be greatly appreciated.

Sincerely,

Gary Smith and Jeanette Finley

APPENDIX B

TABLE III

PROPORTION OF RATERS WHO SAW PRE-POST IMPROVEMENT

PARS Factor	Self (male)	Other (male)	Self (female)	Other (female)
Interpersonal Involvement	.63	.25	.67	.50
Agitation-Depression	.63	.63	.90	.70
Confusion	.88	.63	.80	.30
Outside Social	.75	.50	.82	.18
Household Management	---	---	.90	.50
Alcohol	.75	.13	.67	.44
Anxiety	.75	.38	---	---
Employment	.50	.75	.67	.67
Parenthood Skills	.67	.80	.88	.63
Average % Who Rated Improvement on All Factors	.69	.51	.78	.49

APPENDIX B

TABLE IV

NET POSITIVE OR NEGATIVE CHANGE AS RATED BY MALE AND FEMALE SELF AND INFORMANT

	Male (n=8)			Female (n=11)		
PARS Factor	Self	Informant	t	Self	Informant	t
Interpersonal Involvement	$\bar{x}$ = + .75 s = 4.73	$\bar{x}$ = - .25 s = 5.97	.35 n.s.	$\bar{x}$ = +2.9 (n=10) s = 5.33	$\bar{x}$ = + .30 s = 4.70	.76 n.s.
Agitation-Depression	$\bar{x}$ = +4.75 s = 8.93	$\bar{x}$ = -2.00 s = 4.84	1.30 n.s.	$\bar{x}$ = +7.18 s = 7.71	$\bar{x}$ = +3.50 s = 3.38	1.37 n.s.
Confusion	$\bar{x}$ = +6.38 s = 7.55	$\bar{x}$ = +1.50 s = 5.52	1.38 n.s.	$\bar{x}$ = +4.55 s = 5.59	$\bar{x}$ = - .90 s = 4.35	2.38
Outside Social	$\bar{x}$ = +4.38 s = 4.26	$\bar{x}$ = + .25 s = 2.15	2.31	$\bar{x}$ = +1.18 s = 2.72	$\bar{x}$ = + .36 s = 1.96	.77 n.s.
Household Management	---	---	---	$\bar{x}$ = +2.75 (n=8) s = 4.85	$\bar{x}$ = +2.6 s = 3.85	.07 n.s.
Alcohol	$\bar{x}$ = +2.75 s = 5.53	$\bar{x}$ = 0 s = 3.74	1.09 n.s.	$\bar{x}$ = +2.00 s = 6.14	$\bar{x}$ = - .56 s = 4.32	1.04 n.s.
Anxiety	$\bar{x}$ = +3.00 s = 3.39	$\bar{x}$ = 0 s = 4.27	1.46 n.s.	---	---	---

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TABLE V

SELF AND INFORMANT PRE-POST RATINGS ON MALE CLIENTS

PARS Factor	Self Ratings	Pre	Post	t	Informant Ratings	Pre	Post	t
Interpersonal Involvement	(n=8)	$\bar{x}$ = 35.00 s = 3.84	35.75 3.26	.39 n.s.	(n=8)	$\bar{x}$ = 34.37 s = 6.63	34.12 5.08	.07 n.s.
Agitation-Depression	(n=8)	$\bar{x}$ = 25.12 s = 6.78	20.37 3.38	1.66 n.s.	(n=8)	$\bar{x}$ = 20.87 s = 6.18	21.12 7.25	.07 n.s.
Confusion	(n=8)	$\bar{x}$ = 27.87 s = 5.13	21.50 5.12	2.33	(n=8)	$\bar{x}$ = 25.50 s = 4.54	24.00 5.00	.59 n.s.
Anxiety	(n=8)	$\bar{x}$ = 16.62 s = 3.67	12.25 3.85	2.18	(n=8)	$\bar{x}$ = 23.25 s = 11.92	11.75 4.60	2.39
Alcohol	(n=8)	$\bar{x}$ = 13.75 s = 4.70	11.00 3.32	1.27 n.s.	(n=8)	$\bar{x}$ = 11.12 s = 5.67	11.12 2.99	0 n.s.
Outside Social	(n=8)	$\bar{x}$ = 9.37 s = 3.96	12.25 4.19	1.32 n.s.	(n=8)	$\bar{x}$ = 9.12 s = 3.26	9.12 3.26	0 n.s.
Employment	(n=6)	$\bar{x}$ = 21.33 s = 6.49	21.50 7.58	.03 n.s.	(n=4)	$\bar{x}$ = 23.75 s = 3.95	25.25 4.94	.41 n.s.
Parenthood Skills	(n=6)	$\bar{x}$ = 20.66 s = 2.56	21.83 1.67	.86 n.s.	(n=5)	$\bar{x}$ = 21.20 s = 5.71	23.60 3.71	.70 n.s.

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TABLE VI

SELF AND INFORMANT PRE-POST RATINGS ON FEMALE CLIENTS

PARS Factor	Self Ratings	Pre	Post	t	Informant Ratings	Pre	Post	t
Interpersonal Involvement	(n=10)	$\bar{x}$ = 32.90 s = 6.43	37.20 5.95	1.47 n.s.	(n=10)	$\bar{x}$ = 34.90 s = 7.51	35.20 6.94	.09 n.s.
Agitation-Depression	(n=11)	$\bar{x}$ = 33.18 s = 3.81	26.18 6.85	2.84	(n=10)	$\bar{x}$ = 28.80 s = 6.92	25.30 6.72	1.29 n.s.
Confusion	(n=11)	$\bar{x}$ = 26.81 s = 5.34	22.09 3.95	2.25	(n=10)	$\bar{x}$ = 21.00 s = 6.31	21.90 4.48	.35 n.s.
Alcohol	(n=11)	$\bar{x}$ = 6.27 s = 3.24	4.54 1.82	.82 n.s.	(n=11)	$\bar{x}$ = 5.45 s = 3.27	2.61 .82	.27 n.s.
Outside Social	(n=8)	$\bar{x}$ = 11.37 s = 3.70	13.37 3.42	1.09 n.s.	(n=10)	$\bar{x}$ = 11.80 s = 4.80	13.40 4.07	.83 n.s.
Household Management	(n=11)	$\bar{x}$ = 27.90 s = 7.71	31.09 8.43	.88 n.s.	(n=9)	$\bar{x}$ = 31.00 s = 5.43	30.66 7.35	.16 n.s.
Employment	(n=3)	$\bar{x}$ = 10.66 s = 4.49	24.66 3.09	3.66	(n=3)	$\bar{x}$ = 17.00 s = 6.48	17.00 3.55	0 n.s.
Parenthood Skills	(n=8)	$\bar{x}$ = 22.12 s = 2.54	24.12 3.55	1.22 n.s.	(n=8)	$\bar{x}$ = 21.25 s = 3.79	22.50 3.24	.66 n.s.

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TABLE VII

CORRELATION COEFFICIENTS BETWEEN RATERS

PARS Factor	Male Clients Self vs. Informant			Female Clients Self vs. Informant		
	n	Pre	Post	n	Pre	Post
Interpersonal Involvement	8	.20	.47	9	.68	.75
Agitation	8	-.04	.70	10	.78	.32
Confusion	8	.54	.80	10	-.08	.00
Outside Social	8	.35	.40	11	.56	.80
Household Management	--	----	----	7	.84	.18
Alcohol	8	.88	.87	9	.45	.93
Anxiety	8	.72	.54	--	----	----
Employment	5	.91	.88	2	.89	1.00
Parenthood Skills	5	.56	.88	7	.37	-.37
Average Correlations*		.51	.69		.56	.45

*unweighted

APPENDIX C

TABLE VIII